

No. 2  
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5-17-39  
X47020

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9444**  
**1349**  
Registrar's No.

**FILED APR 1 1947**  
Registration District No. **149**

Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether  
In this community life.  
years, months or days)

3. (a) PRINT FULL NAME Stephen Maxwell Taylor  
3. (b) If veteran, name war no.  
3. (c) Social Security No. no.

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced unknown  
6. (b) Name of husband or wife X  
6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased November 2 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 4 18 hr. min.

9. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business X

MOTHER FATHER

12. Name unknown  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruth Shuck

(b) Address 1201 N. 18th St., K. C., Kas.

17. (a) burial (b) Date thereof 3-22-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 3-22-47 Aladdin Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 603 E. 12 St.  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20  
year 1947 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from  
March 16 1947 to March 20 1947  
that I last saw him alive on March 20 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchiectasis and bronchopneumonia  
Generalized arteriosclerosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy See above

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature W. W. Hart (M. D. or other) 728  
Address Med Dir. Gen'l Hosp. Date signed 3-21-47

*Dr. C. J. ...*

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*[Handwritten Signature]*  
.....  
Licensed Embalmer No. *1415*  
P. O. Address *H. C. ...*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**